tient who did so well after tonsillectomy had quite a severe hemorrhage a few hours after returning to the ward; possibly it was the hemorrhage rather than the removal of the tonsils which raised her leukocyte count.

The various liver extracts seem useless, and no chemical has any specific effect. On the theory that while heavy exposures of x-ray depress the bone marrow, small doses are stimulating, Friedemann reported using minimal radiation of the long bones with miraculously prompt benefit. A later report by Friedemann and Elkeles [18] does not sound so optimistic, nor has the treatment been favorably reported upon by others, although tried in many cases. Of the four patients on whom I have seen it tried, none experienced the prompt feeling of well-being nor did young granular cells appear in the blood, as it has been claimed.

We must learn the underlying cause of the leukopenia which is the basis of so-called agranulocytic angina, in order that treatment may be directed not only at the local ulcerations, at the need of circulating leukocytes and at the dormant marrow, but also at this underlying cause whether it prove to be allergy or some still unsuspected factor.

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THE MENTAL HYGIENE SURVEY OF CALIFORNIA*

PART I

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LONG ago mental disorders were regarded with the same misunderstanding that gave rise to myths. Eventually came the recognition of the major psychotic disorders as medical problems. Until the twentieth century, however, medical principles were applied almost solely to the more apparent adult psychotic and psychoneurotic disorders. Then came the knowledge that these disorders are the outgrowth of conditions existent in the childhood of the subjects and might have been prevented had proper approach been made. Preventive mental endeavor so became concentrated in the child rather than in the adult. Now it is further recognized that mental hygiene work cannot be complete without combined work with the child, the persons with whom the child comes into contact and the other environmental factors. Treatment of the child (or of the adult) cannot be detached from a total situation involving home, parents, brothers and sisters, school, neighborhood and companions. Psychotherapy must be applied to persons and psychiatric social therapy to situations.

MENTAL HYGIENE PROBLEMS CONFRONT ALL PHYSICIANS

Every practitioner of medicine, no matter what his specialty, is confronted with a great number of mental hygiene problems. His ability to meet such problems depends upon his understanding of them through education and practical experience. His education usually has been wholly inadequate ("only seventeen of the sixty-four four-year medical schools in the United States require of their students as much as one hundred hours of psychiatric study" [1]) and he is prone to develop erroneous concepts through unguided experience. Understanding of the psychotic or psychoneurotic adult cannot be complete without understanding of the child and the situational influences that tend to the development of deviations from the normal personality. Such understanding is to be had only through special work with children such as, for example, has been developed in child-guidance clinics with the characteristic personnel set-up centered around psychiatrist, psychologist, and psychiatric social worker. Professional education is thus of utmost importance, in order that the medical practitioner not only shall treat his patients wisely but that he shall disseminate practical information and advice to the public personally or through writing. Similar education is needed by public health officers, nurses, social workers, teachers, administrators, recreation directors, policemen, probation officers, judges and practicing lawyers. Constructive education is the backbone of the mental hygiene approach.

UNITED STATES STATISTICS ON HOSPITALS FOR THE MENTALLY ILL

Mental health has been defined as "the adjustment of individuals to themselves and to the world at large with a maximum of effectiveness, satisfactions, cheerfulness and socially considerate behavior, and the ability to face and accept the realities of life." [2] Obviously the field of mental hygiene is a vast one. In federal, state, county, city, and other hospitals for nervous and mental patients in the United States, there was in the year 1930 an average daily census of 415,042 patients, representing a net increase over the year 1929 of 19,635. In total capacity, the 561 nervous and mental hospitals exceeded the 4302 general hospitals by 66,310 beds.[1] It has been found that there are, in mental hospitals, 250 patients over fifteen years of age for every 100,000 of the general population; 80 (per 100,000 population) are admitted each year, 70 of these for the first time. It has been estimated that "the

* Read before the Neuropsychiatry Section of the California Medical Association at the sixtieth annual session at San Francisco, April 27-30, 1931.

Editor's Note.—See, also, a preliminary report on the California State Mental Hygiene Survey in December 1930 California and Western Medicine, page 872.

chances of persons, living in states with good facilities, being committed to hospitals for the mentally ill in the course of their lifetimes, are about one in twenty. The chances of developing a psychosis or a severely incapacitating neurosis (whether the patient is sent to hospital or not) are about one in ten."[2] In addition, there are habit problems, socially objectionable behavior and personality problems preventing the individual from achieving healthy personality organization that will permit him to be satisfied and satisfying in social relationships. Allied to such problems are delinquency, crime, poverty and dependency, with their enormous costs.

THE 1930 MENTAL HYGIENE SURVEY OF CALIFORNIA

In the summer of 1930, a mental hygiene survey of the State of California was made under the direction of Frederick H. Allen, M. D. A preliminary report of the survey has been published[3] but the completed report is not yet in print. With the permission of Doctor Allen and with due credit to him for material used, as much of his findings and recommendations follow as is possible to include in a paper of this length. It is regretted that only brief abstracts of the voluminous report can be here presented. It should be mentioned that criticism, where it appears, is meant to be constructive in character and applied to conditions generally recognized and understood by the personnel of the state institutions who have, in most instances, made the effort to bring about betterment of the conditions criticized.

CALIFORNIA FACILITIES FOR STUDY, CARE, AND TREATMENT OF THE MENTALLY SICK

In 1930, there were approximately 18,000 mental patients in the state, private and other hospitals of California. The way that they are supervised, cared for and treated is a mental hygiene problem of great importance. The nature of mental conditions frequently requires that hospital care shall be enforced through legal procedure. The procedure of commitment should be such as to minimize the legal compulsory aspect and to emphasize the medical treatment of the patient as the major consideration.

Present Commitment Law in California.—The present commitment law in California is based upon the assumption that a person with mental disorder, to be commitable, must be dangerous to himself and to the property and life of others. This concept was formulated when the law was passed in 1864 and this part of the law has never been changed. The medical aspect of commitment which emphasizes hospitalization as treatment, is given little consideration. Commitment is mainly a legal procedure to provide custody for the patient and safety for the community. A complaint of insanity is made and a warrant is issued by a magistrate. The sheriff takes the patient into custody and detains him in a "suitable place." Each county has used its own judgment concerning the type of quarters to be regarded as suitable, with the result that all kinds of conditions exist, varying from good hospital care to the very worst of jail conditions. In some counties there is overlapping of such facilities. In 1929, 890 insanity warrants were issued in thirty counties that still use county jails for detention of mental patients, and a large proportion of these patients were held in jail pending legal disposition. In 1929, 1646 mental patients were disposed of in seventeen counties that have transferred the jail quarters to the county hospitals. Thus forty-seven of the fifty-eight California counties provided either jails or jail-like facilities for the detention of mental patients pending further disposition. In 1929, eleven counties with 3865 insanity complaints appear to have approached this problem from a medical point of view. Six of them not only provided good hospital facilities, but also facilities for examination and temporary treatment. All patients, nevertheless, were arraigned before a superior court judge who set the time for the trial, telling the patient that he has the right to have counsel and to produce witnesses. The law provides that the hearing shall be held in "open court" and the patient must be present if physically able. The complaining witnesses must state before him the reasons for regarding him to be "insane." Two physicians must be present to hear the evidence and to examine the patient. Examination is usually made just preceding the hearing or at the time of the hearing. Only four counties have their own staff of visiting psychiatrists who examine all patients independently of the court. In many counties, including some of the larger cities, the best that can be said of the examination is that it gives the proceeding a slight medical coloring. If commitment is decided upon, the patient is turned back to the sheriff for transportation to the hospital. It is still a common procedure to handcuff patients while they are en route to the state hospital. Of the last fifty admissions to one state hospital, it was found that 46 per cent came to the hospital under some form of physical restraint. Steel cuffs and leather belts were used in most cases. Practically all of these patients quickly settled into the routine of the hospital. It is thus clear that restraint is essential only when the care is unintelligent. The unwise procedure previous to hospitalization too frequently creates excitement and makes restraint necessary. The law makes illegal the commitment of a patient from his own home, although many counties practice this procedure. It makes no provision for temporary commitment. It provides for jury trials on demand by a patient and in those criminal cases in which the plea is brought "not guilty by reason of insanity." The procedure provides influences detrimental to the patient's best interests and detrimental to the recovery of his normal mental condition. It helps to maintain an archaic, erroneous and unscientific attitude concerning the nature of mental disease and prevents the building up of a better conception of mental illness. The law was originally designed to prevent unwise hospitalization, but

better safeguards are in use. State hospital staffs are adequately able to determine what patients do not need to be in mental hospitals and authority is vested in the superintendents to return such persons to the community at once. The medical profession can be trusted to exercise this function with discretion. There must be some legal formality to the commitment procedure, inasmuch as the patient is deprived of his liberty, property rights are involved and detention by force is sometimes indicated. Other states have been able to make these legal formalities of commitment extremely simple. In the present commitment procedure the judge can, if he chooses, reject the opinions of the examining physicians and he has been known to do so. The function of the judge in a commitment procedure should consist in no more than the mere formality necessary from the legal standpoint, including the legal protection of the physicians signing the commitment orders.

Suggested Changes for a New California Commitment Law.—The following changes are suggested for a new commitment law:

1. To permit a relative to make application for mental examination of a person thought to be mentally ill. This application should be signed by the local health officer, who should be responsible to see that examination is made.

2. To have examination made by two qualified physicians, either at the patient's home or at a suitable place provided by the county. If detention is necessary, it should be in or connected with a hospital and not in jail. Every man or woman licensed to practice medicine in California, who has practiced for five years, should be qualified to sign commitment papers.

3. Papers to be presented to a magistrate or superior court judge, to be sworn to and recorded. The patient should not be required to appear before a judge or in court unless he demands it.

4. Immediate transportation from the patient's own home to a mental hospital to be made possible. A corps of trained attendants from the state hospitals and paid by the state should be responsible for this duty.

5. Provision to be made by the state for the establishment of receiving hospitals at various convenient points to allow for reception and examination of patients from the smaller counties.

6. Temporary commitment to any approved psychopathic ward to be made possible. Such commitment should be authorized on the certificate of one qualified physician, to run for a period of ten days. This would simplify the machinery of getting immediate hospital care in the case of urgency.

7. Every patient to have the right to demand a court hearing before a board of experts appointed by the court.

8. In the case of the relatively small percentage of dangerous and violent patients pending hospitalization, it should be possible to have the assistance of local peace officers.

9. Commitment to be made possible to a few specially licensed private hospitals.

Present Psychopathic Parol Act.—In 1927, the attempt was made to introduce more elasticity into the commitment procedure by the passage of the Psychopathic Parole Act. This provides for the examination of persons mentally sick and bordering upon insanity, but not dangerously insane. Such persons are placed in charge of the psychopathic parole officer and are allowed to remain at home, or the court can direct that they be placed in suitable homes or sanitaria subject to the supervision of the psychopathic parole officer. This Act seems to emphasize the legal fallacy about insanity. It attempts to restate the legal attitude that a mental patient, to be commitable, must be dangerous. If he is not dangerous, then he is not legally insane and must be called mentally sick. It is a curious attempt on the part of the law to bring the provisions more in keeping with the medical attitude toward mental patients. It has, however, allowed the courts in two counties to keep certain patients under observation without commitment to a state hospital. As long as the law allows commitment only to the state institutions, this additional provision has helped. If the present provisions of the Psychopathic Parole Act are continued, this work should be in charge of persons who have definite qualifications which should be written into the Act and the work should be under good medical supervision.

Hospital Care of Mental Patients in California. Only one private general hospital in the state makes any provision for the treatment of mental patients. Some 627 patients were cared for in the last fiscal year. All were maintained on a voluntary basis. They were carefully studied by the psychiatric staff, assisted by the senior students of a medical school. The ward is used essentially for teaching purposes and the histories obtained are quite complete. It is in charge of a graduate nurse, and pupil nurses rotate through the service. This ward demonstrates the feasibility and necessity of having a ward for mental patients as a regular part of a general hospital. It is enabling a medical school to teach the subject of psychiatry adequately. There is a marked scarcity of general hospital facilities for mental patients in California. More large general hospitals should equip a ward for such patients and should attach a psychiatrist to their staff. The treatment facilities of a hospital cannot be regarded as complete until this gap is filled.

Four county hospitals do something more than keep mental patients pending commitment. Only one county hospital has developed a psychopathic department which has no relation to the commitment procedure. Most of the patients are admitted on a voluntary basis and are kept for twelve days. Diagnosis rather than treatment is emphasized as the major function.

Better facilities in counties are needed for the care of those aged persons who require only good

custodial care. Such facilities should be developed at county farms and should be used only for such persons and not for those patients in need of treatment. Smaller counties should join together on this project.

The state hospitals for the mentally sick are charged with the medical and social responsibility for a large number of sick persons, both while they are patients in the hospitals and while they are readjusting to the normal life in the community. The work of these hospitals forms an important chapter in the mental hygiene program of any state. California's first state hospital was established in 1860 and, continuously since then, the state has not deviated from the policy of complete state care, although one large county under the operation of the Psychopathic Parole Act has cared for large numbers of patients without commitment. California has six hospitals devoted entirely to the care of mentally sick patients. On June 30, 1930, they were caring for 14,906 patients; and 1293 were on parole or otherwise absent. This gives a ratio of 261 state hospital patients to 100,000 general population. During 1929, 5752 insanity complaints were issued and 4540 patients were admitted to these hospitals—a ratio of 83 patients to 100,000 general population. In the last fifteen years, California has almost doubled in general population, but the number of patients in state hospitals has not grown proportionately. The drop in ratio does not mean that mental disease is decreasing; it probably means that a building program has not been maintained to meet the needs of a rapidly growing state.

RECOMMENDATIONS PROPOSED TO INCREASE EFFICIENCY OF STATE HOSPITALS

A few of the recommendations follow, meant to better equip the state hospitals for their important clinical responsibilities: Expansion of capacity to 19,000 beds within five years, with replacement of antiquated buildings unsuitable for the care of sick persons; financial support to provide a per capita allowance of at least one dollar a day (now about sixty-nine cents a day); conversion of two state hospitals, proximate respectively to Los Angeles and San Francisco, into acute psychopathic hospitals; better record work through larger medical staff, more use of trained social workers, more stenographic assistance and statistical service from the Department of Institutions. Each hospital should have: a reception service to maintain continuous treatment of approximately 10 per cent of the total hospital population; a well trained clinical director, with full time for clinical activities; at least one physician to 200 patients (now 1 to 304); a trained pathologist; at least one full-time dentist to every 1500 patients; a chief physiotherapist with four to six assistants; the application of a well-planned occupational therapy program to every patient capable of being benefited by activity; a recreational director; a trained psychiatric nurse with graduate standing in charge of nursing and attendant personnel and responsible for their assignments; one attendant to every nine patients (now 1 to 11.3).† Increase in salaries is indicated all down the line.

"CRIMINAL INSANE" AND DRUG PATIENTS

The term "criminal insane" has little validity, as the study indicates that a large proportion of these patients showed evidence of mental disturbance before the criminal act was committed. Better psychiatric facilities in community and court would effect the commitment to hospital of more of these patients before the commission of a criminal act. Custodial facilities in one of the state hospitals will be expanded to care for 300 of these patients, according to present building plans. These additional quarters should permit transfer of custodial patients from the other hospitals and should entirely relieve San Quentin prison of those mental patients now being kept in the so-called "crazy alley." This is the top gallery of one of the cell blocks, which has been set aside for the housing of this group. These men do no work, but are kept away from contact with the rest of the prison population and spend a large part of their time in their cells. These psychotic patients are only the more obvious ones. Mixed in with the 7000 men in San Quentin and Folsom prisons are large numbers—no one knows how many—who are definitely insane.

The drug colony needs a great deal more equipment both for treatment and for occupational therapy. This hospital should have an adequate social service staff both for assistance in obtaining histories and for supervision of patients on parole.

(To be continued)

PARALYSIS—FROM SPURIOUS JAMAICA GINGER EXTRACT*

REPORT ON LOS ANGELES COUNTY OUTBREAK

By FRANK G. CRANDALL, M. D.
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BEFORE January 15, 1931, the disease or condition known as "jake paralysis" was unknown in California except for the reports of an outbreak of Jamaica ginger paralysis which occurred last year in the middle western and southern states. Therefore, nothing of the character of "jake paralysis" was suspected by a physician in Whittier when, on January 18, a man aged sixty, with symptoms of nausea and vomiting, abdominal cramps and a severe diarrhea, was visited.

REPORT OF CASE

The patient was sent into the local hospital. Laboratory tests for amebic and bacillary dysentery were

† The budget passed by the 1931 legislature provides for the biennium, a ratio of one attendant to ten patients.

* From the health department of the county of Los Angeles.

* For other comment on "jake paralysis," see California and Western Medicine, November 1930, page 823, and May 1931, page 378.